

Indiana State Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005075 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 06/13/2012 |
| NAME OF PROVIDER OR SUPPLIER ST VINCENT HOSPITAL & HEALTH SERVICES | | STREET ADDRESS, CITY, STATE, ZIP CODE 2001 W 86TH ST INDIANAPOLIS, IN 46260 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| S 000 | <p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State licensure complaint.</p> <p>Complaint Number: IN00101706 Unsubstantiated: Lack of sufficient evidence</p> <p>Facility #: 005075</p> <p>Survey Dates: 06-13-12</p> <p>Surveyor: Billie Jo Fritch RN, BSN, MBA Public Health Nurse Surveyor</p> <p>St.Vincent Hospital and Health Services was found in compliance with 410 IAC 15-1.5-6, Nursing services; 410 IAC 15-1.5-10, Discharge planning; and 410 IAC 15-1.5-5, Physician services, Hospital Licensure Rules.</p> <p>QA: claughlin 06/19/12</p> | S 000 | | |

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE